Action details

Person responsible:	Monica Boldeata
Location:	Beaumont Manor
Due date:	01-Apr-2026
Details of action required:	An important part of Candour of duty is to provide an annual report about the duty of candour in our service. This short report describes how the Care Home has operated the duty of candour during the last year.
Closed date:	08-Apr-2026

Form - Duty of Candour Annual Report

All health and social care services in the UK have Duty of Candour responsibilities. This is a legal requirement which means that when things go wrong and mistakes happen, the people affected understand what has happened, receive an apology and organisations learn how to improve for the future.

An important part of this duty is to provide an annual report about the duty of candour in our service. This short report describes how the Care Home has operated the duty of candour during the last year. We hope you find this report useful.

What year does this annual report relate to?: 2025

Who is completing the report: BEM40343

Job Role: Home manager

Provide a short narrative about your service: Beaumont Manor Care Home, located in the seaside town of Frinton-on-Sea, provides a welcoming and supportive environment for up to 91 residents. The home offers a full range of services, including residential, nursing, dementia, and respite care, all delivered with a strong focus on dignity, comfort, and individual wellbeing.
With a compassionate and experienced team, Beaumont Manor delivers person-centred care tailored to each resident's needs, promoting independence while ensuring safety and reassurance. Comfortable surroundings, engaging activities, and a homely atmosphere help residents feel valued, connected, and truly at home.

Within the last 12 months, how many incidents have there been at the home, to which the duty of candour applied.: 4

Types of Unexpected or Unintended incidents specified within the legislation

Someone???s sensory, motor, or intellectual function is impaired for 28 days or more.

Number of people affected (just add number - no details)	0

Someone has experienced pain or psychological harm for 28 days or more.

Number of people affected (just add number - no details)	2

A person needed health treatment to prevent them from dying.

Number of people affected (just add number - no details)	0

A person needed health treatment to prevent other injuries.

Number of people affected (just add number - no details)	0

The structure of someone???s body changes because of harm/injury.

Number of people affected (just add number - no details)	0

Someone???s treatment has increased because of harm.

Number of people affected (just add number - no details)	0

Someone???s life expectancy becomes shorted because of harm.

Number of people affected (just add number - no details)	0

Someone has permanently lost bodily, sensory, motor, or intellectual functions because of harm.

Number of people affected (just add number - no details)	0

Someone has died.

Number of people affected (just add number - no details)	0

When you realised the event(s) above had happened, did you follow the correct procedure.: YES

Did you review what happened and what if anything, went wrong to try and learn for the future.: YES

When something has happened that triggers the duty of candour, do staff report this to the Home Manager who has responsibility for ensuring that the Duty of Candour procedure is followed?: YES

Does the Home Manager record the incident or accident and reports it as necessary to the CI/ CQC/CIW, the local contracting authority, the Regional Director, and the Quality Director, for the company.: YES

Do all new staff learn about the duty of candour at their induction?: YES

When an incident or accident has happened, does the Home Manager and staff set up a learning review?: YES

Please provide a short explanation of the learning from any Duty of Candours (Please do not provide any information that could identify individual residents): In 2025, there were four reported incidents within the service. These included two deep tissue injuries affecting two residents, one medication error involving a single resident, and one fall which resulted in a significant haematoma to a resident's forehead and a laceration to the eye.
For each incident, a thorough review was undertaken and lessons learned were identified. These findings were shared with the team through flash meetings and clinical meetings to promote learning, improve practice, and reduce the risk of recurrence.

Duty of candour informs our learning and planning for improvements as a service, and as a company. It has helped us to remember that people who use our services have the right to know when things could be better, as well as when they go well.

Do you confirm that you have made this report available to the regulator but in the spirit of openness, have also published it to share with residents and their relatives too.: YES